

General Information for Authorization

SELANCAS MONTHISM	acon .					r			
Org 1.508			Serv	Service Type 2. V					
					Client Ir	forma	tion		
Name 3. CLIENT NAME						Clier	Client ID 4. 123456789WA		
Living Arra	ngements	5.				Refe	rence Auth #	6.	
					Provider	Inform	ation		
Requesting	NPL#	7. 11234567	789		Requesting Fax #		uesting Fax #	8. XXXXXXXXX	
Servicing N	NPI#	9. 11234567	89	-,		Nam	ne	10. SERVICING PROVINAME	IDER
Referring N	NPI #	11. 1123456	789		Referring Fax #		rring Fax#	12. XXXXXXXXX	
Service Sta		13.						14. N/A	
Date:									
	-			Sei	rvice Requ	est Inf	formation		
Description	n of service be	eina requeste	d:						
	onal Vision S	•			16. N/A		N/A	17. N/A	
18. Serial /	NEA# N/A					19. N/A			
20. Code	21. Nationa	22. Mod	23. # U	Inits/Days	24. \$ Amount			25. Part #	26. Tooth
Qualifier	Code		Re	equested	Reques	ted		(DME Only)	or Quad #
C	CPT				N/A			N/A · ·	
P	HCPCS								
			-				-		
					Medical	nform	ation		
Diagnosis Code 27. ICD-9 Diagnosis name				28.					
Place of service 29. 11					0.2.004.00				
30. Commo	30. Comments:								

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The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. HIPAA Compliance: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD	NAME	ACTIO	N ELDS MUST BE TYPED.					
	Org required	Enter the Number that Matches the Program/Unit for the Request						
1		500 - Division of Alcohol and Substance Abuse (DASA) 501 - Dental 502 - Durable Medical Equipment (DME) 509 - Economic Services Administration (ESA) (DSHS) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 507 - Juvenile Rehabilitation Administration (JRA) (DSHS) 508 - Medical 509 - Medical Nutrition 510 - Mental Health 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 516 - Miscellaneous						
	Service Type required	Enter th	Enter the letter(s) in all CAPS that represent the service type you are requesting.					
•		AA BB BEM BGM BGS BP BS BSS2 C CI CIERP CSC CWN DASA DEN	Ambulatory Aids Bath Bench Bath Equipment (misc) Blood Glucose Monitors Bone Growth Stimulator Breast Pumps Bariatric surgery Bariatric surgery stage 2 Commode Cochlear Implants Cochlear Implant Ext Repl Prts Commode/Shower Chair Crowns DASA Dentures	PHY PL PMR PROS PRS PSY PTL PWH PWNF	Orthopedic Shoes Orthotics PAS Duty Nursing Pharmacy Patient Lifts PM and R Prosthetics Prone Standers Psychotherapy Partial Power Wheelchair - Home Power Wheelchair - NF Power Wheelchair - NF			
2		EN ESA FSFS HB HEA HH HSPC IPT ITA JRA LTAC MC MISC MN MWNF O ODC ODME OOS OP	Enteral Nutrition ESA Floor Sitter/Feeder Seat Hospital Beds Hearing Aids Home Health Hospice Infusion/Parental Therapy Inpatient admission - ITA JRA LTAC Medication Miscellaneous Medical Nutrition Manual Wheelchair - Home Manual Wheelchair - NF Other Orthodontic Other DME Out of State Ostomy Products	PHYS R RBS RE RLNS RM S SC SCAN SF SGD SSIP T TRN TU US V VNSS VOL WDCS	Physician Services Respiratory Rebases Room equipment Relines Readmission Surgery Specialty Beds/Surfaces Shower chairs MRI/PET Scans Standing Frames Speech Generating Device Short Stay (In-Patient) Therapies (PT/OT/ST) Transportation TENS Units Urinary Supplies Vision Vagus nerve stimulator surgery Inpatient admission-Voluntary Wound/decubiti care supplies			

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
•	Client ID: Required.	Enter the client ID = 9 numbers followed by WA.
4		 For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). A reference PA will be built with a placeholder client ID. If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <u>Billing Instructions</u> and <u>fee schedules</u> for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

ALL FIELDS MUST BE TYPED Org required Enter the Number that Matches the 500 – Division of Alcohol and Subs 501 – Dental 502 – Durable Medical Equipment 509 – Economic Services Administ	stance Abuse (DASA) (DME)					
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501 Dental 502 Durable Medical Equipment	(DME)					
502 Durable Medical Equipment						
509 Economic Services Administ	.t ome the owner to					
1	509 Economic Services Administration (ESA) (DSHS)					
504 - Home Health						
505 - Hospice						
506 - Inpatient Hospital						
1 507 - Juvenile Rehabilitation Admi	nistration (JRA) (DSHS)					
508 - Medical						
509 Medical Nutrition	509 Medical Nutrition					
510 - Mental Health						
	511 - Outpt Proc/Diag					
	513 Physical Medicine & Rehabilitation (PM & R)					
	513 - Thysical rectionic & Remaintantion (Three ts) 514 - Aging and Disability Services Administration (ADSA)					
	515 Transportation					
516 - Miscellaneous						
Service Type required Enter the letter(s) in all CAPS that is	Enter the letter(s) in all CAPS that represent the service type you are					
requesting.						
AA Ambulatory Aids						
BB Bath Bench						
BEM Bath Equipment (mi						
BGM Blood Glucose Mon						
BGS Bone Growth Stimu	llato r					
BP Breast Pumps						
BS Bariatric surgery						
BSS2 Bariatric surgery sta	i ge 2					
G Commode						
CI Cochlear Implants						
CIERP Cochlear Implant Ex						
2 CSC Commode/Shower C	Shair					
CWN Crowns						
DASA DASA						
DEN Dentures EN Enteral Nutrition						
ESA ESA						
FSFS Floor Sitter/Feeder \	Sant					
HB Hospital Beds	Jeac					
HEA Hearing Aids						
HH Home Health	·					
HSPC Hospice						
IPT Infusion/Parental Th	nerany					
ITA Inpatient admission						
JRA JRA						
LTAC LTAC						

Field	Name	Action		
		MC	Medication	
		MISC	Miscellaneous	
		MN	Medical Nutrition	
		MWH	Manual Wheelchair - Home	
		MWNF	Manual Wheelchair - NF	
	·	θ	Other	
•		ODC	Orthodontic	
		ODME	Other DME	
		oos	Out of State	
		OP	Ostomy Products	
		OS	Orthopedic Shoes	
•		OTC	Orthotics	
		PAS	PAS	
		PDN	Private Duty Nursing	
		PHY	Pharmacy	
		PL	Patient Lifts	
		PMR	PM and R	
		PROS	Prosthetics	
		PRS	Prone Standers	
		PSY	Psychotherapy	
		PTL	Partial	
		₽₩Ħ	Power Wheelchair - Home	
		PWNF	Power Wheelchair NF	
		PWNF	Power Wheelchair - NF	
		PHYS	Physician Services	
		R	Respiratory	
		RBS	Rebases	
		RE	Room equipment	
		RLNS	Relines	
		RM	Readmission	
		S	Surgery	
		SBS	Specialty Beds/Surfaces	
		SC	Shower chairs	
		SCAN	MRI/PET Scans	
		SF	Standing Frames	
	•	SGD	Speech Generating Device	
		SSIP	Short Stay (In Patient)	
		Ŧ	Therapies (PT/OT/ST)	
		TRN	Transportation	
		TU	TENS Units	
		US	Urinary Supplies	
		V	Vision	
		VNSS	Vagus nerve stimulator surgery	
		VOL	Inpatient admission-Voluntary	
		WDCS	Wound/decubiti care supplies	
•	Name: Required.		st name, first name, and middle initial of the patient you	
3	•	are requesting authorization for.		
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4	1			

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5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc. NOT REQUIRED FOR VISION SERVICES
6	Reference Auth #:	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI#: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#:	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the
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21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
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24	\$ Amount Requested: Required.	NOT REQUIRED FOR VISION SERVICES Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee

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Field	Name	Action	
	·	schedules for assistance) Must be entered in dollars & cents with a	
		decimal (e.g. \$400 should be entered as 400.00.	
25	Part # (DME only): Required for	NOT REQUIRED FOR VISION SERVICES Enter the	
45	all "By Report" codes requested.	manufacturer part # of the item requested.	
	Tooth or Quad#: Required for	NOT REQUIRED FOR VISION SERVICES	
	dental requests	Enter the tooth or quad number as listed below:	
		QUAD	
		00 - full mouth	
		01 upper arch	
26		02 lower arch	
20		10 upper right quadrant	
		20 upper left quadrant	
	·	30 lower left quadrant	
		40 lower right quadrant	
		Tooth # 1-36, A.T., AS TS, 51-82 and SN	
27	Diagnosis Code:	Enter appropriate diagnosis code for condition.	
28	Diagnosis name	Short description of the diagnosis.	
20	Place of Service	Enter the appropriate two digit place of service code.	
29		Use 11 for office	
30	Comments: Enter any free form information you deem necessary.		